AMENDED IN SENATE AUGUST 17, 2010

AMENDED IN SENATE JUNE 16, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 2470

Introduced by Assembly Member De La Torre

February 19, 2010

~~An act to add Sections 1389.9, 1389.10, 1389.11, 1389.13, 1389.14, 1389.15, 1389.16, 1389.17, 1389.18, 1389.19, 1389.20, 1389.22, 1389.23, and 1389.24 to the Health and Safety Code, and to add Sections 10384.12, 10384.14, 10384.16, 10384.18, 10384.2, 10384.22, 10384.24, 10384.26, 10384.28, 10384.29, 10384.3, 10384.32, 10384.34, and 10396 to, the Insurance Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.~~ *An act to amend Sections 1365, 1367.15, 1389.21, and 1389.3 of, and to repeal Sections 1357.11, 1357.53, and 1357.54 of, the Health and Safety Code, and to amend Sections 10176.10, 10273.5, 10384, and 10384.17 of, to repeal Sections 10273.6 and 10713 of, and to repeal and add Section 10273.4 of, the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2470, as amended, De La Torre. ~~Individual health care coverage.~~ *Health care coverage: cancellation: rescission.*

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of its provisions a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. ~~Existing law prohibits the Director of the Department of Managed Health Care~~

~~and the Insurance Commissioner from approving a health care service plan contract or health insurance policy without a finding that the application for the contract or policy conforms to specified requirements. Existing law prohibits the cancellation or nonrenewal of an enrollment or subscription by a health care service plan except in specified circumstances, including failure to pay the charge for the coverage, fraud or deception in the use of services or facilities, or other good cause as agreed upon in the contract.~~ Existing law prohibits the *cancellation or* nonrenewal of individual *or group* health benefit plans by a *health care service plan or a* health insurer except in specified circumstances, including for nonpayment of premiums or for fraud or ~~intentional~~ misrepresentation ~~of material fact~~, *as specified, and gives an enrollee of a health care service plan contract a right to appeal a cancellation or nonrenewal to the Director of the Department of Managed Health Care. Existing law prohibits a plan or insurer from engaging in postclaims underwriting, as defined, and from rescinding an individual contract or policy for any reason, or canceling the contract or policy due to misrepresentation, as specified, after 24 months following issuance of the contract or policy*.

~~Existing law subjects health care service plans to various fines and administrative penalties for failing to comply with specified provisions of the act and requires that certain fines and administrative penalties be deposited in the Managed Care Administrative Fines and Penalties Fund. Under existing law, the Managed Risk Medical Insurance Board manages the California Major Risk Medical Insurance Program (MRMIP) to provide health care coverage to eligible persons who have been rejected for coverage by at least one private health plan. Existing law creates the Major Risk Medical Insurance Fund, and continuously appropriates the fund to the board for purposes of the program.~~

This bill would *make that 24-month limit apply to all health care service plan contracts and health insurance policies and would consolidate various cancellation and nonrenewal provisions. The bill would also* prohibit a plan or insurer from ~~canceling or~~ rescinding an individual health care service plan contract or individual health insurance policy ~~because of misrepresentation unless specified conditions are met and would require that plan or insurer decisions to cancel or rescind pursuant to that provision be reviewed by an independent review process that the bill would establish in the Department of Managed Health Care and the Department of Insurance commencing March 31, 2011. The bill would require plans and insurers to provide specified notices to~~

~~subscribers, enrollees, policyholders, and insureds concerning potential rescissions or cancellations and the independent review process and would also require a plan or insurer to annually report to the department the total number of individual health care service plan contracts or individual health insurance policies issued, canceled, or rescinded pursuant to these provisions during the preceding calendar year. The bill would require affected plans and insurers, as specified, to pay the cost of the independent review system pursuant to an assessment fee system established by the Director of Managed Health Care and the Insurance Commissioner. The bill would also impose administrative penalties upon a plan or insurer that engages in any conduct that has the effect of prolonging an independent review process or that fails to implement an independent review process decision. The bill would require that penalties collected from plans be deposited into the Managed Care Administrative Fines and Penalties Fund, and that penalties collected from insurers be deposited into the Major Risk Medical Insurance Fund for purposes of MRMIP, subject to appropriation by the Legislature. The bill would exempt certain types of plans and policies from the bill's requirements and would enact related provisions.~~ *, or limiting any of the provisions of the contract or policy, once an enrollee or insured is covered under the contract or policy unless the plan or insurer can demonstrate that the enrollee or insured has performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the contract or policy. The bill would require a plan or insurer to send a notice to the enrollee or subscriber or policyholder or insured at least 30 days prior to the effective date of the rescission containing specified information. The bill would modify the cancellation and nonrenewal appeal rights that apply to health care service plans and would make those appeal rights apply to health insurers and rescissions, as specified. The bill would make other related changes.*

Because this bill would impose additional requirements on health care service plans, the willful violation of which would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~This bill would declare that it is to take effect immediately as an urgency statute.~~

Vote: ~~⅔~~ *majority*. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1357.11 of the Health and Safety Code is repealed.

~~1357.11. All health care service plan contracts offered to a small employer shall be renewable with respect to all eligible employees or dependents at the option of the contractholder or small employer except:~~

~~(a) For nonpayment of the required premiums by the contractholder or small employer.~~

~~(b) For fraud or misrepresentation by the contractholder or small employer or, with respect to coverage of individuals, the individuals or their representatives.~~

~~(c) For noncompliance with a plan's participation or employer contribution requirements at the time of renewal.~~

~~(d) When the plan ceases to provide or arrange for the provision of health care services for new small employer health care service plan contracts in this state; provided, however, that the following conditions are satisfied:~~

~~(1) Notice of the decision to cease new or existing small employer health benefits plans in this state is provided to the director and to either the contractholder or small employer at least 180 days prior to the discontinuation of the coverage.~~

~~(2) Small employer health care service plan contracts subject to this chapter shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan which remains in force, any plan that ceases to offer for sale new small employer health care service plan contracts shall continue to be governed by this article with respect to business conducted under this article.~~

~~(3) Except as authorized under subdivision (d) of Section 1357.09 and Section 1357.10, a plan that ceases to write new small employer business in this state after the effective date of this article shall be prohibited from offering for sale new small employer~~

~~health care service plan contracts in this state for a period of five years from the date of notice to the director.~~

~~(e) When the plan withdraws a health care service plan contract from the small employer market; provided, the plan notifies all affected contractholders or small employers and the director at least 90 days prior to the discontinuation of those contracts, and the plan makes available to the small employer all plan contracts that it makes available to new small employer business; and provided, that the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1357.12.~~

SEC. 2. Section 1357.53 of the Health and Safety Code is repealed.

~~1357.53. All group health benefit plans shall be renewable with respect to the contractholder or employer except as follows:~~

~~(a) For nonpayment of the required premiums by the contractholder or employer.~~

~~(b) For fraud or other intentional misrepresentation of material fact by the contractholder or employer.~~

~~(c) For noncompliance with a material plan contract provision.~~

~~(d) If the plan ceases to provide or arrange for the provision of health care services for new health benefit plans in the state; provided, however, that the following conditions are satisfied:~~

~~(1) Notice of the decision to cease new or existing group health benefit plans in the state shall be provided to the director and to either the contractholder or employer at least 180 days prior to discontinuation of this coverage.~~

~~(2) Group health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan that remains in force, any plan that ceases to offer for sale new group health benefit plans shall continue to be governed by this section with respect to business conducted under this section.~~

~~(3) Except as authorized under subdivision (d) of Section 1357.09 and Section 1357.10, a plan that ceases to write new group health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale group health benefit plans in this state for a period of five years from the date of notice to the director.~~

~~(e) If the plan withdraws a group health benefit plan from the market; provided, that the plan notifies all affected contractholders~~

~~or employers and the director at least 90 days prior to the discontinuation of these plans, and that the plan makes available to the employer all health benefit plans that it makes available to new employer business without regard to the claims experience or health-related factors of enrollees.~~

SEC. 3. Section 1357.54 of the Health and Safety Code is repealed.

~~1357.54. All individual health benefit plans, except for short-term limited duration insurance, shall be renewable with respect to all eligible individuals or dependents at the option of the individual except as follows:~~

~~(a) For nonpayment of the required premiums or contributions by the individual in accordance with the terms of the health insurance coverage or the timeliness of the payments.~~

~~(b) For fraud or intentional misrepresentation of material fact under the terms of the coverage by the individual.~~

~~(c) Movement of the individual contractholder outside the service area, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.~~

~~(d) If the plan ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state; provided, however, that the following conditions are satisfied:~~

~~(1) Notice of the decision to cease new or existing individual health benefit plans in the state is provided to the director and to the individual at least 180 days prior to discontinuation of that coverage.~~

~~(2) Individual health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan that remains in force, any plan that ceases to offer for sale new individual health benefit plans shall continue to be governed by this section with respect to business conducted under this section.~~

~~(3) A plan that ceases to write new individual health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale individual health benefit plans in this state for a period of five years from the date of notice to the director.~~

~~(e) If the plan withdraws an individual health benefit plan from the market; provided, that the plan notifies all affected individuals~~

~~and the director at least 90 days prior to the discontinuation of these plans, and that the plan makes available to the individual all health benefit plans that it makes available to new individual business without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.~~

SEC. 4. Section 1365 of the Health and Safety Code is amended to read:

1365. (a) An enrollment or a subscription ~~may~~ *shall* not be canceled or not renewed except for the following *reasons*:

(1) ~~Failure to pay the charge for such coverage~~ *For nonpayment of the required premiums by the individual or group subscriber* if the subscriber has been duly notified and billed for the charge and at least 15 days has elapsed since the date of notification.

~~(2) Fraud or deception in the use of the services or facilities of the plan or knowingly permitting such fraud or deception by another.~~

~~(3) Such other good cause as is agreed upon in the contract between the plan and a group or the subscriber.~~

(2) The plan demonstrates fraud or an intentional misrepresentation of material fact under the terms of the health care service plan contract by the individual or group subscriber.

(3) In the case of an individual health care service plan contract, the individual subscriber no longer resides, lives, or works in the plan's service area, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(4) In the case of a group health care service plan contract, violation of a material contract provision relating to employer contribution or group participation rates by the subscriber. This paragraph shall become operative on January 1, 2014.

(5) If the plan ceases to provide or arrange for the provision of health care services for new health care service plan contracts in the individual or group market, or all markets, in this state, provided, however, that the following conditions are satisfied:

(A) Notice of the decision to cease new or existing health care service plan contracts in the state is provided to the director and to the individual or group subscriber, and the enrollees covered under those contracts, at least 180 days prior to discontinuation of those contracts.

(B) Health care service plan contracts shall not be canceled for 180 days after the date of the notice required under subparagraph (A) and for that business of a plan that remains in force, any plan that ceases to offer for sale new health care service plan contracts shall continue to be governed by this section with respect to business conducted under this section.

(C) Except as authorized under subdivision (b) of Section 1357.09 and Section 1357.10, a plan that ceases to write new health care service plan contracts in the individual or group market, or all markets, in this state shall be prohibited from offering for sale health care service plan contracts in that market or markets in this state for a period of five years from the date of the discontinuation of the last coverage not so renewed.

(6) If the plan withdraws a health care service plan contract from the market, provided that all of the following conditions are satisfied:

(A) The plan notifies all affected subscribers and enrollees and the director at least 90 days prior to the discontinuation of those contracts.

(B) The plan makes available to the individual or group subscriber all health care service plan contracts that it makes available to new individual or group business, respectively.

(C) In exercising the option to discontinue a health care service plan contract under this paragraph and in offering the option of coverage under subparagraph (B), the plan acts uniformly without regard to the claims experience of the individual or group subscriber, or any health-status related factor relating to enrollees or potential enrollees.

(D) For small employer health care service plan contracts offered under Article 3.1 (commencing with Section 1357), the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1357.12.

(b) *(1)* An enrollee or subscriber who alleges that an enrollment or subscription has been *or will be improperly* canceled, *rescinded,* or not renewed ~~because of the enrollee's or subscriber's health status or requirements for health care services~~ may request a review by the director. ~~If~~

(2) The director shall review a request under paragraph (1) within seven days. If the director determines that a proper complaint exists ~~under the provisions of this section~~, the director shall

immediately notify the plan *and the enrollee or subscriber who requested the review*. Within 15 days after receipt of ~~such~~ *that* notice, the plan shall either request a hearing or reinstate the enrollee or subscriber. ~~If,~~

(3) If the plan requests a hearing under paragraph (2), the director shall hold the hearing within 15 days of the request and shall give the plan and the enrollee or subscriber sufficient notice of the date and location of the hearing. The enrollee or subscriber and his or her representative may attend and participate in the hearing.

(4) If, after *the* hearing *under paragraph (3)*, the director determines that the cancellation, *rescission*, or failure to renew is contrary to ~~subdivision (a)~~ *existing law*, the director shall *immediately* order the plan to reinstate the enrollee or subscriber. ~~A~~

(5) A reinstatement pursuant to this subdivision shall be *immediate and* retroactive to the time of cancellation, *rescission*, or failure to renew and the plan shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation, *rescission*, or nonrenewal to and including the date of reinstatement. *The amount of expenses incurred that the plan shall reimburse to the enrollee or subscriber shall be determined by the director using reasonable documentation submitted by the enrollee or subscriber.*

(c) This section shall not abrogate any preexisting contracts entered into prior to the effective date of this chapter between a subscriber or enrollee and a health care service plan or a specialized health care service plan including, but not limited to, the financial liability of ~~such~~ *the* plan, except that each plan shall, if directed to do so by the director, exercise its authority, if any, under ~~any such~~ *those* preexisting contracts to conform them to the provisions of ~~subdivision (a)~~ *existing law*.

SEC. 5. Section 1367.15 of the Health and Safety Code is amended to read:

1367.15. (a) This section shall apply to individual health care service plan contracts and plan contracts sold to employer groups with fewer than two eligible employees as defined in subdivision (b) of Section 1357 covering hospital, medical, or surgical expenses, which is issued, amended, delivered, or renewed on or after January 1, 1994.

(b) As used in this section, "block of business" means individual plan contracts or plan contracts sold to employer groups with fewer than two eligible employees as defined in subdivision (b) of Section 1357, with distinct benefits, services, and terms. A "closed block of business" means a block of business for which a health care service plan ceases to actively offer or sell new plan contracts.

(c) No block of business shall be closed by a health care service plan unless (1) the plan permits an enrollee to receive health care services from any block of business that is not closed and ~~which~~ *that* provides comparable benefits, services, and terms, with no additional underwriting requirement, or (2) the plan pools the experience of the closed block of business with all appropriate blocks of business that are not closed for the purpose of determining the premium rate of any plan contract within the closed block, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool.

(d) A block of business shall be presumed closed if either of the following is applicable:

(1) There has been an overall reduction in that block of 12 percent in the number of in force plan contracts for a period of 12 months.

(2) That block has less than 1,000 enrollees in this state. This presumption shall not apply to a block of business initiated within the previous 24 months, but notification of that block shall be provided to the director pursuant to subdivision (e).

The fact that a block of business does not meet one of the presumptions set forth in this subdivision shall not preclude a determination that it is closed as defined in subdivision (b).

(e) A health care service plan shall notify the director in writing within 30 days of its decision to close a block of business or, in the absence of an actual decision to close a block of business, within 30 days of its determination that a block of business is within the presumption set forth in subdivision (d). When the plan decides to close a block, the written notice shall fully disclose all information necessary to demonstrate compliance with the requirements of subdivision (c). When the plan determines that a block is within the presumption, the written notice shall fully disclose all information necessary to demonstrate that the presumption is applicable. In the case of either notice, the plan

shall provide additional information within 15 days after any request of the director.

(f) A health care service plan shall preserve for a period of not less than five years in an identified location and readily accessible for review by the director all books and records relating to any action taken by a plan pursuant to subdivision (c).

(g) No health care service plan shall offer or sell any contract, or provide misleading information about the active or closed status of a block of business, for the purpose of evading this section.

(h) A health care service plan shall bring any blocks of business closed prior to the effective date of this section into compliance with the terms of this section no later than December 31, 1994.

(i) This section shall not apply to health care service plan contracts providing small employer health coverage to individuals or employer groups with fewer than two eligible employees if that coverage is provided pursuant to Article 3.1 (commencing with Section 1357) and, with specific reference to coverage for individuals or employer groups with fewer than two eligible employees, is approved by the director pursuant to Section 1357.15, provided a plan electing to sell coverage pursuant to this subdivision shall do so until such time as the plan ceases to market coverage to small employers and complies with *paragraph (5) of* subdivision ~~(c)~~ *(a)* of Section ~~1357.11~~ *1365*.

(j) This section shall not apply to coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, dental, vision, or conversion coverage.

SEC. 6. Section 1389.21 of the Health and Safety Code is amended to read:

1389.21. *(a) A health care service plan shall not rescind a plan contract, or limit any provisions of a plan contract, once an enrollee is covered under the contract unless the plan can demonstrate that the enrollee has performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the contract.*

(b) If a plan intends to rescind a plan contract pursuant to subdivision (a), the plan shall send a notice to the enrollee or subscriber via regular certified mail at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and notifying the enrollee or subscriber of his

or her right to appeal that decision to the director pursuant to subdivision (b) of Section 1365.

(c) Notwithstanding *subdivision (a), Section 1365 or* any other provision of law, after 24 months following the issuance of ~~an individual~~ *a* health care service plan contract, a plan shall not rescind the plan contract for any reason, and shall not cancel the plan contract, limit any of the provisions of the plan contract, or raise premiums on the plan contract due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not. Nothing in this ~~section~~ *subdivision* shall be construed to alter existing law that otherwise applies to a health care service plan within the first 24 months following the issuance of ~~an individual~~ *a* health care service plan contract.

SEC. 7. Section 1389.3 of the Health and Safety Code is amended to read:

1389.3. No health care service plan shall engage in the practice of postclaims underwriting. For purposes of this section, "postclaims underwriting" means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. This section shall not limit a plan's remedies ~~upon a showing of willful misrepresentation~~ *described in subdivision (a) of Section 1389.21 or paragraph (2) of subdivision (a) of Section 1365*.

SEC. 8. Section 10176.10 of the Insurance Code is amended to read:

10176.10. (a) On or after January 1, 1994, no disability insurer issuing policies covering hospital, surgical, or medical expenses delivered or renewed in this state or certificates of group disability insurance delivered or renewed in this state pursuant to a master group policy delivered or renewed in another state, to individuals, or to employer groups with fewer than two eligible employees, as defined in subdivision (g) of Section 10700, shall close a block of business without complying with this section.

(b) As used in this section, "block of business" means individual, group, or blanket disability insurance contracts covering hospital, medical, or surgical expenses of a particular policy form that has distinct benefits or marketing methods. "Closed block of business" means a block of business for which an insurer ceases to actively

market and sell new contracts under a particular policy form in this state.

(c) Notwithstanding subdivision (b), a block of business shall be presumed closed if either of the following applies:

(1) There has been an overall reduction of 12 percent in the number of in force policies of a particular form for a period of 12 months.

(2) The block has less than 2,000 insured nationally or 1,000 insureds in California. This presumption shall not apply to a block of business initiated within the previous 24 months, but notification of that block shall be provided to the commissioner. The notification shall not be subject to the approval required by subdivision (d).

An insurer may present evidence for consideration by the commissioner that the presumption in the particular case is incorrect. Should the determination be made that the block is closed, the insurer shall be given those remedy options contained in subdivision (d). The fact that a block of business does not meet one of the presumptions set forth in this subdivision shall not preclude a determination that it is closed as defined in subdivision (b).

(d) An insurer shall notify the commissioner within 30 days of its decision to close a block or, in the absence of an actual decision to close a block of business, within 30 days of its determination that the block is within the presumptions set forth in subdivision (c). The commissioner may notify an insurer that he or she has determined that the presumptions contained in subdivision (c) apply to a block. No insurer providing disability insurance covering hospital, medical, or surgical expenses shall close a policy form or group certificate without notification to the commissioner. That notification shall include a plan to permit an insured to move to any open block, providing comparable benefits with no additional underwriting requirement or, alternatively, the insurer shall be required to pool the closed block's experience with all appropriate open forms for purposes of renewal rate determination, with no rate penalty or surcharge, beyond that which reflects the experience of the combined pool. When the insurer chooses to pool, the notice shall include the insurer's plan for pooling the closed block's experience. The insurer may implement the pooling plan if 30 days expire after the submission is filed without written notice from the

commissioner specifying the reasons for his or her opinion that the pooling plan does not comply with the requirements of this section, or, prior to that time, if the commissioner provides the insurer written notice that the pooling plan complies with the requirements of this section.

The approval shall be based upon consideration of the accumulative recent and expected future experience of the closed form and those with which the closed form is to be combined.

(e) No insurer shall offer or sell any form nor provide misleading information about the active or closed status of its business for the purpose of evading this section.

(f) An insurer shall bring any blocks of business closed prior to the effective date of this section into compliance with the terms of this section no later than December 31, 1994.

(g) This section shall not apply to small employer carriers providing small employer health insurance to individuals or employer groups with fewer than two eligible employees if that coverage is provided pursuant to Chapter 14 (commencing with Section 10700) of Part 2 of Division 2, and with specific reference to coverage for individuals or employer groups with fewer than two eligible employees, is approved by the commissioner pursuant to Section 10705, provided a carrier electing to sell coverage pursuant to this subdivision shall continue to do so until such time as the carrier ceases to market coverage to small employers and complies with *paragraph (5) of* subdivision ~~(c)~~ *(a)* of Section ~~10713~~ *10273.4*.

(h) This section shall not apply to accident only coverage, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, long-term care insurance, dental, vision, or conversion coverage, coverage issued as a supplement to liability insurance, or automobile medical payment insurance.

SEC. 9. Section 10273.4 of the Insurance Code is repealed.

~~10273.4. All disability insurers writing, issuing, or administering group health benefit plans shall make all of these health benefit plans renewable with respect to the policyholder, contractholder, or employer except in case of the following:~~

~~(a) Nonpayment of the required premiums by the policyholder, contractholder, or employer.~~

~~(b) Fraud or other intentional misrepresentation by the policyholder, contractholder, or employer.~~

~~(c) Noncompliance with a material health benefit plan contract provision.~~

~~(d) The insurer ceases to provide or arrange for the provision of health care services for new group health benefit plans in this state, provided that the following conditions are satisfied:~~

~~(1) Notice of the decision to cease writing, issuing, or administering new or existing group health benefit plans in this state is provided to the commissioner and to either the policyholder, contractholder, or employer at least 180 days prior to discontinuation of that coverage.~~

~~(2) Group health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan that remains in force, any disability insurer that ceases to write, issue, or administer new group health benefit plans shall continue to be governed by this section with respect to business conducted under this section.~~

~~(3) Except as provided under subdivision (h) of Section 10705, or unless the commissioner had made a determination pursuant to Section 10712, a disability insurer that ceases to write, issue, or administer new group health benefit plans in this state after the effective date of this section shall be prohibited from writing, issuing, or administering new group health benefit plans to employers in this state for a period of five years from the date of notice to the commissioner.~~

~~(e) The disability insurer withdraws a group health benefit plan from the market; provided, that the plan notifies all affected contractholders, policyholders, or employers and the commissioner at least 90 days prior to the discontinuation of the health benefit plans, and that the insurer makes available to the contractholder, policyholder, or employer all health benefit plans that it makes available to new employer business without regard to the claims experience of health-related factors of insureds or individuals who may become eligible for the coverage.~~

~~(f) For the purposes of this section, "health benefit plan" shall have the same meaning as in subdivision (a) of Section 10198.6 and Section 10198.61.~~

~~(g) For the purposes of this section, "eligible employee" shall have the same meaning as in Section 10700, except that it applies~~

~~to all health benefit plans issued to employer groups of two or more employees.~~

SEC. 10. Section 10273.4 is added to the Insurance Code, to read:

10273.4. (a) A health insurance policy shall not be canceled or not renewed except for the following reasons:

(1) Nonpayment of the required premiums by the individual or group policyholder if the policyholder has been duly notified and billed for the charge and at least 15 days has elapsed since the date of notification.

(2) The insurer demonstrates fraud or an intentional misrepresentation of material fact under the terms of the health insurance policy by the individual or group policyholder.

(3) In the case of an individual health insurance policy that offers coverage through a network, the individual policyholder no longer resides, lives, or works in the network service area, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(4) In the case of a group health insurance policy, violation of a material policy provision relating to employer contribution or group participating rates by the policyholder. This paragraph shall become operative on January 1, 2014.

(5) If the insurer ceases to provide new health insurance policies in the individual or group market, or all markets, in this state, provided, however, that the following conditions are satisfied:

(A) Notice of the decision to cease new or existing health insurance policies in the state is provided to the commissioner and to the individual or group policyholder, and the insureds covered under those policies, at least 180 days prior to discontinuation of those policies.

(B) Health insurance policies shall not be canceled for 180 days after the date of the notice required under subparagraph (A) and for that business of an insurer that remains in force, any insurer that ceases to offer for sale new insurance policies shall continue to be governed by this section with respect to business conducted under this section.

(C) Except as authorized under subdivision (d) of Section 10711 and Section 10712, an insurer that ceases to write new health insurance policies in the individual or group market, or all markets, in this state shall be prohibited from offering for sale health

insurance policies in that market or markets in this state for a period of five years from the date of the discontinuation of the last coverage not so renewed.

(6) If the insurer withdraws a health insurance policy from the market, provided that all of the following conditions are satisfied:

(A) The insurer notifies all affected policyholders and insureds and the commissioner at least 90 days prior to the discontinuation of those policies.

(B) The insurer makes available to the individual or group policyholder all health insurance policies that it makes available to new individual or group business, respectively.

(C) In exercising the option to discontinue a health insurance policy under this paragraph and in offering the option of coverage under subparagraph (B), the insurer acts uniformly without regard to the claims experience of the individual or group policyholder, or any health-status related factor relating to insureds or potential insureds.

(D) For small employer health insurance policies offered under Chapter 8 (commencing with Section 10700), the premium for the new insurance policies complies with the renewal increase requirements set forth in Section 10714.

(b) (1) A policyholder or insured who alleges that a policy has been or will be improperly canceled, rescinded, or not renewed may request a review by the commissioner.

(2) The commissioner shall review a request under paragraph (1) within seven days. If the commissioner determines that a proper complaint exists, the commissioner shall immediately notify the insurer and the policyholder or insured who requested the review. Within 15 days after receipt of that notice, the insurer shall either request a hearing or reinstate the policyholder or insured.

(3) If the insurer requests a hearing under paragraph (2), the commissioner shall hold the hearing within 15 days of the request and shall give the insurer and the policyholder or insured sufficient notice of the date and location of the hearing. The policyholder or insured and his or her representative may attend and participate in the hearing.

(4) If, after the hearing under paragraph (3), the commissioner determines that the cancellation, rescission, or failure to renew is contrary to existing law, the commissioner shall immediately order the insurer to reinstate the policyholder or insured.

(5) A reinstatement pursuant to this subdivision shall be immediate and retroactive to the time of cancellation, rescission, or failure to renew and the insurer shall be liable for the expenses incurred by the policyholder or insured for covered health care services from the date of cancellation, rescission, or nonrenewal to and including the date of reinstatement. The amount of expenses incurred that the insurer shall reimburse to the policyholder or insured shall be determined by the commissioner using reasonable documentation submitted by the policyholder or insured.

(c) This section shall not abrogate any preexisting policies entered into prior to the effective date of this part between a policyholder or insured and a health insurer including, but not limited to, the financial liability of the insurer, except that each insurer shall, if directed to do so by the commissioner, exercise its authority, if any, under those preexisting policies to conform them to the provisions of existing law.

SEC. 11. Section 10273.5 of the Insurance Code is amended to read:

10273.5. No person shall cause or permit to be issued, circulated or used any representation that a policy ~~defined~~ *described* in Section 10273.3 is "non-can," noncancelable (not cancelable) or noncancelable and guaranteed renewable.

No person shall cause or permit to be issued, circulated or used any representation concerning the right to continue a policy such as is defined in Section 10273.3 unless such representation contains a declaration of the terms under which the insurer has reserved the right to change the premium in a manner which shall not minimize or obscure the same.

Any person knowingly violating any provision of this section shall be subject to the penalties provided for misrepresentation by this code.

SEC. 12. Section 10273.6 of the Insurance Code is repealed.

~~10273.6. All individual health benefit plans, except for short-term limited duration insurance, shall be renewable with respect to all eligible individuals or dependents at the option of the individual except as follows:~~

~~(a) For nonpayment of the required premiums or contributions by the individual in accordance with the terms of the health insurance coverage or the timeliness of the payments.~~

~~(b) For fraud or intentional misrepresentation of material fact under the terms of the coverage by the individual.~~

~~(c) Movement of the individual contractholder outside the service area but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals.~~

~~(d) If the disability insurer ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state; provided, however, that the following conditions are satisfied:~~

~~(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the commissioner and to the individual policy or contractholder at least 180 days prior to discontinuation of that coverage.~~

~~(2) Individual health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a disability insurer that remains in force, any disability insurer that ceases to offer for sale new individual health benefit plans shall continue to be governed by this section with respect to business conducted under this section.~~

~~(3) A disability insurer that ceases to write new individual health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale individual health benefit plans in this state for a period of five years from the date of notice to the commissioner.~~

~~(e) If the disability insurer withdraws an individual health benefit plan from the market; provided, that the disability insurer notifies all affected individuals and the commissioner at least 90 days prior to the discontinuation of these plans, and that the disability insurer makes available to the individual all health benefit plans that it makes available to new individual businesses without regard to a health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.~~

SEC. 13. Section 10384 of the Insurance Code is amended to read:

10384. No insurer issuing or providing any policy of disability insurance covering hospital, medical, or surgical expenses shall engage in the practice of postclaims underwriting. For purposes of this section, “postclaims underwriting” means the rescinding, canceling, or limiting of a policy or certificate due to the insurer’s failure to complete medical underwriting and resolve all reasonable

questions arising from written information submitted on or with an application before issuing the policy or certificate. *This section shall not limit an insurer's remedies described in subdivision (a) of Section 10384.17 or paragraph (2) of subdivision (b) of Section 10273.4.*

SEC. 14. Section 10384.17 of the Insurance Code is amended to read:

10384.17. *(a) A health insurer shall not rescind a health insurance policy, or limit any provisions of a health insurance policy, once an insured is covered under the policy unless the insurer can demonstrate that the insured has performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the policy.*

(b) If a health insurer intends to rescind a health insurance policy pursuant to subdivision (a), the insurer shall send a notice to the policyholder or insured via regular certified mail at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and notifying the policyholder or insured of his or her right to appeal that decision to the commissioner pursuant to subdivision (b) of Section 10273.4.

(c) Notwithstanding *subdivision (a) of Section 10273.4 or* any other provision of law, after 24 months following the issuance of ~~an individual~~ *a* health insurance policy, a health insurer shall not rescind the policy for any reason, and shall not cancel the policy, limit any of the provisions of the policy, or raise premiums on the policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not. Nothing in this ~~section~~ *subdivision* shall be construed to alter existing law that otherwise applies to a health insurer within the first 24 months following the issuance of ~~an individual~~ *a* health insurance policy.

SEC. 15. Section 10713 of the Insurance Code is repealed.

~~10713. All health benefit plans written, issued, or administered by carriers on or after the effective date of this chapter, and all health benefit plans in force on or after the effective date of this chapter shall be renewable with respect to all eligible employees or dependents at the option of the policyholder, contractholder, or small employer except as follows:~~

~~(a) For nonpayment of the required premiums by the policyholder, contractholder, or small employer.~~

~~(b) For fraud or misrepresentation by the policyholder, contractholder, or small employer or, with respect to coverage of individual enrollees, the enrollees or their representative.~~

~~(c) For noncompliance with a carrier's participation or employer contribution requirements at the time of renewal.~~

~~(d) When the carrier ceases to write, issue, or administer new small employer health benefit plans in this state, provided, however, that the following conditions are satisfied:~~

~~(1) Notice of the decision to cease writing, issuing, or administering new or existing small employer health benefits plans in this state is provided to the commissioner, and to either the policyholder, contractholder, or small employer at least 180 days prior to the discontinuation of the coverage.~~

~~(2) Small employer health benefit plans subject to this chapter shall not be canceled for 180 days after the date of the notice required under paragraph (1). For that business of a carrier that remains in force, any carrier that ceases to write, issue, or administer new health benefit plans shall continue to be governed by this chapter.~~

~~(3) Except in the case where a certification has been approved pursuant to subdivision (h) of Section 10705 or the commissioner has made a determination pursuant to subdivision (a) of Section 10712, a carrier that ceases to write, issue, or administer new health benefit plans to small employers in this state after the passage of this chapter shall be prohibited from writing, issuing, or administering new health benefit plans to small employers in this state for a period of five years from the date of notice to the commissioner.~~

~~(e) When a carrier withdraws a benefit plan design from the small employer market, provided that the carrier notifies all affected policyholders, contractholders, or small employers and the commissioner at least 90 days prior to the discontinuation of those contracts, and that the carrier makes available to the small employer all small employer benefit plan designs which it markets and satisfies the requirements of paragraph (3) of subdivision (b) of Section 10714.~~

SEC. 16. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or

infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

All matter omitted in this version of the bill appears in the bill as amended in the Senate, June 16, 2010. (JR11)

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